CRYPTOSPORIDIOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49687 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Diarrhea
- ○ Abdominal Cramps
- ○ Weight Loss *(lbs)*
- ○ Vomiting
- ○ Loss of Appetite
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Method of Testing Used:
- ○ Modified Acid-Fast Stain
- ○ DFA Stain
- ○ EIA
- ○ No Positive Test
- ○ Other, specify:

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

Physician/Hospital Phone - -

Was the patient hospitalized?
○ Yes ○ No **If Yes, admission date:** / /
Discharge date: / /
Hospital:

Was the patient treated with antimicrobials for this illness? ○ Yes ○ No ○ Unknown

If Yes, antimicrobial

Date started / / **Date ended** / /

Was the patient immunocompromised? ○ Yes ○ No ○ Unknown

If Yes, why

Did the patient die? ○ Yes ○ No

Section 3. Epidemiologic Information

From where did the patient drink water during the two weeks prior to illness onset (e.g. , "HOME", "WORK", "SCHOOL", "DAY CARE")?

Site:	Water Source:				
	○ City	○ Well	○ Surface	○ Other, specify:	
	○ City	○ Well	○ Surface	○ Other, specify:	
	○ City	○ Well	○ Surface	○ Other, specify:	
	○ City	○ Well	○ Surface	○ Other, specify:	

Indicate whether the patient consumed the following foods and beverages during the 2 weeks prior to illness onset.

Food Item:	Date Consumed:	Brand Name:	Name of Place Purchased:
○ Unpasteurized milk	/ /		
○ Unpasteurized juice	/ /		
○ Raw fruit/vegetables	/ /		

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Section 4. Risk Factors

During the two weeks prior to onset of symptoms, did the patient:

Go swimming?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__
Location:

Use a hot tub or whirlpool?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__
Location:

Visit an interactive fountain or water park?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__
Location:

Drink untreated surface water?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__
Location:

Have contact with anyone who had similar symptoms or was diagnosed with cryptosporidiosis?
○ Yes ○ No ○ Unknown **If Yes, name:**
Phone number: ___-___-____
Onset date: __/__/__
Relationship:

Have contact with farm animals?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__

Did any of the animals have or develop diarrhea?
○ Yes ○ No ○ Unknown **Type of animal:**

Have contact with any pets?
○ Yes ○ No ○ Unknown **If Yes, date:** __/__/__

Have any of the pets had diarrhea?
○ Yes ○ No ○ Unknown **Type of pet:**

Attend or work in a day-care center or institution for the developmentally disabled?
○ Yes ○ No ○ Unknown

If Yes, where

__/__/__
Date

Travel outside of Indiana?
○ Yes ○ No ○ Unknown

If Yes, where

__/__/__ **Date of departure** __/__/__ **Date of return**

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Section 4. Risk Factors (continued)

List number of sexual partners in the two weeks prior to the onset of the symptoms:

Males: ___ **Females:** ___ ○ **None** ○ **Unknown**

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number ___ - ___ - ____ **Date** __ / __ / __